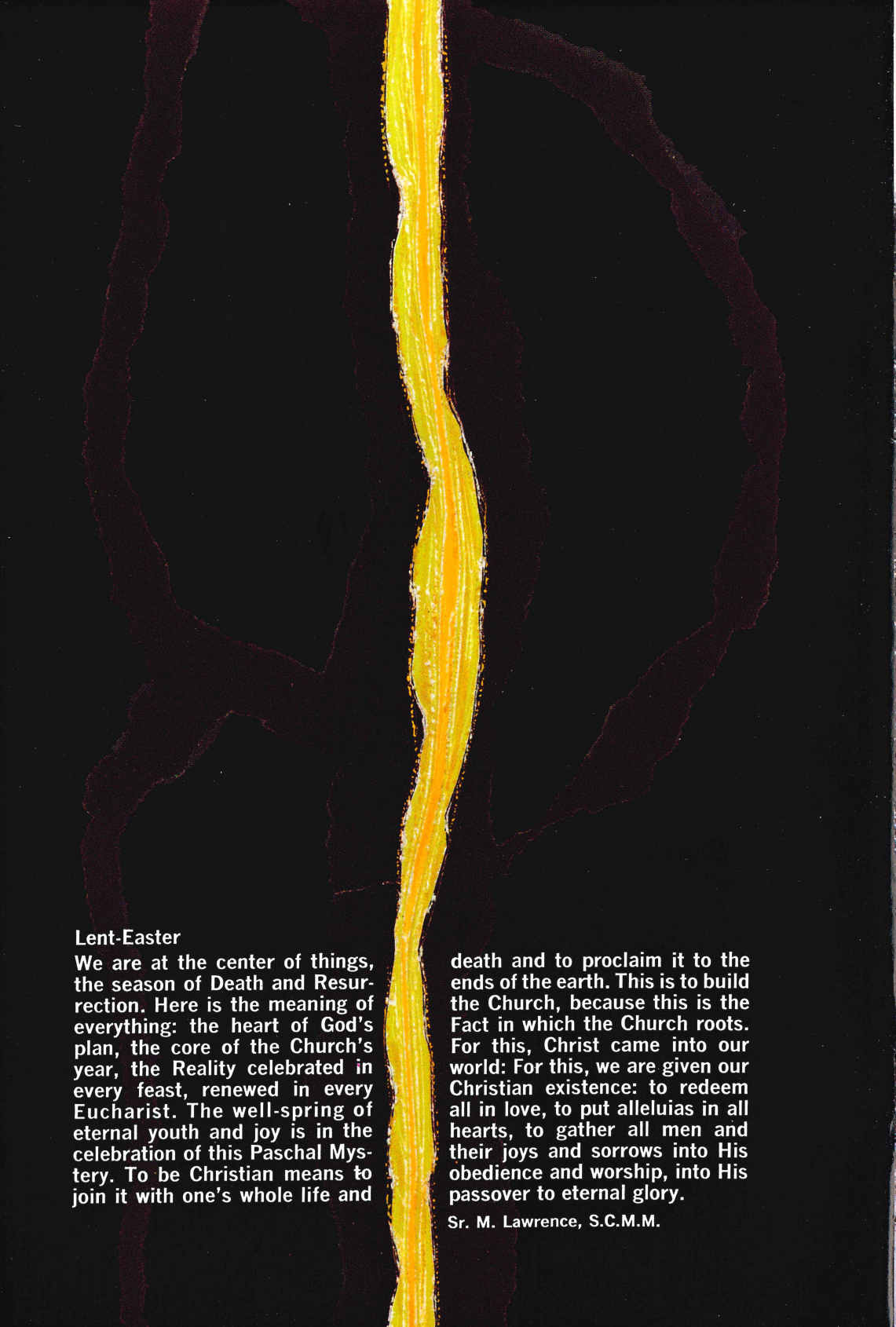
medical missionary

MARCH-APRIL, 1964



Lent-Easter

We are at the center of things, the season of Death and Resurrection. Here is the meaning of everything: the heart of God's plan, the core of the Church's year, the Reality celebrated in every feast, renewed in every Eucharist. The well-spring of eternal youth and joy is in the celebration of this Paschal Mystery. To be Christian means to join it with one's whole life and death and to proclaim it to the ends of the earth. This is to build the Church, because this is the Fact in which the Church roots. For this, Christ came into our world: For this, we are given our Christian existence: to redeem all in love, to put alleluias in all hearts, to gather all men and their joys and sorrows into His obedience and worship, into His passover to eternal glory.

Sr. M. Lawrence, S.C.M.M.

THE medical missionary

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Cover: Ugandan farmer carrying stalk of plantain, the staple food.

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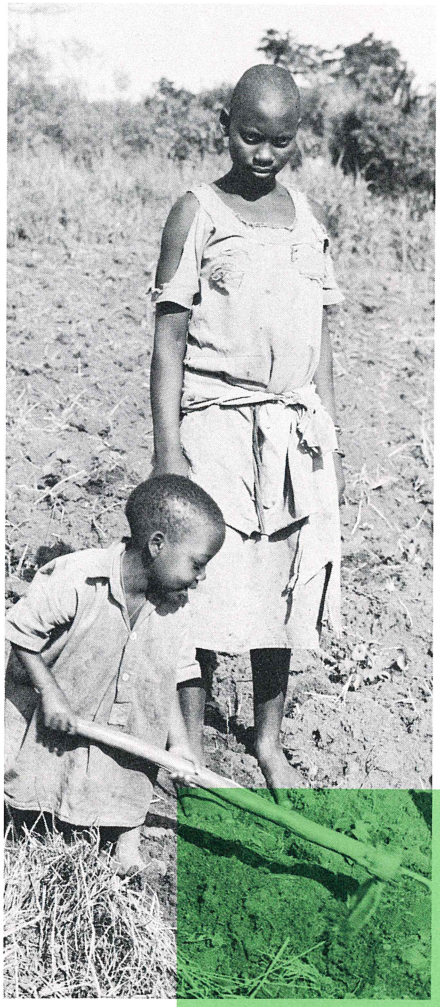
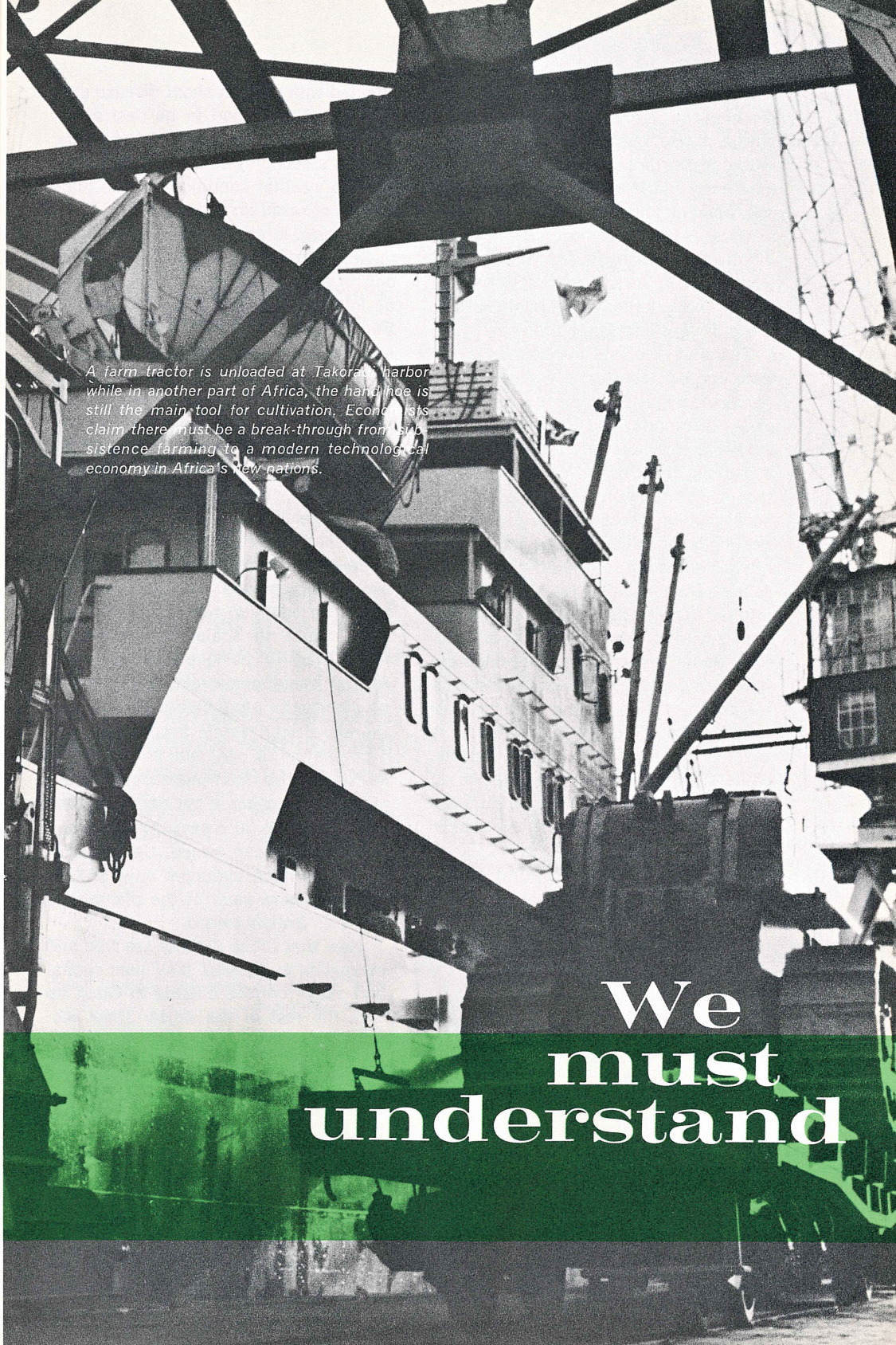
The Challenge Of Economics For The Medical Mission Apostolate In East And West Africa Today.



The CBS News Telecast, "Years of Crisis," on New Year's Day 1964, characterized the status of the African Nations as "Have Not Nations." It is true that most African nations are poor by modern standards in spite of their vast resources of mineral wealth. Recent statistics show that less than five per cent of Africa's population is employed (Ghana has the best record—15 per cent); others fall into the category of peasants, unemployed or inadequately employed (working only certain months of the year). Africans in both East and West face the immediate and crucial need of increasing agricultural and economic output to meet the demands of the rising expectations of their peoples, newly awakened to what the "Have Nations" possess.

This is the challenge of the hour—this is the revolution taking place in all Africa today—Africa changing rapidly from a primitive, non-industrial, agricultural, subsistence economy where each family raised only enough for its own needs, to an exchange, money and market economy. Under the subsistence economy an African family has scarcely enough to exist and in case of drought or floods whole tribes perish.

Generally speaking, the economic development of Africa, with the exception of the Union of South Africa, dates back to the end of the 19th century. What were the causes of this delay? Among the most important were the difficulties connected with gaining access to the coast, the shortage and inadequacy of transport and communications and, above all, the high incidence of tropical disease. Here we see the intimate relationship between eco-



A farm tractor is unloaded at Takoradi harbor while in another part of Africa, the hand hoe is still the main tool for cultivation. Economists claim there must be a break-through from subsistence farming to a modern technological economy in Africa's new nations.

We must understand

nomics and health problems. Sleeping sickness, as found in Africa, occurs nowhere else; malaria there is transmitted by the most efficient and dangerous vector found anywhere; smallpox is still present and outbreaks still occur in West Africa; onchocerciasis (river blindness) is estimated to affect some 20 million in Africa, particularly West Africa. T.B., leprosy and malnutrition are still very important problems.

The first colonists to come to Africa were quick to see Africa's great potential, especially its immense wealth in gold, diamonds and other minerals. Economic activities naturally were aimed at serving the colonial country without too much attention being paid to the necessity of investing in education, health, technical training and community development for the Africans themselves. Economically, Africa is divided into mineral and agricultural territories. East and West Africa lie in the agricultural areas, where recent development has been dependent on a one cash crop — cocoa, coffee, tea, cotton or sisal raising. Ghana's cocoa, for instance, is responsible for 70% of its exports, while nearly 90% of the exports of Kenya and Uganda are agricultural: cotton in Uganda; tea, coffee, sisal in Kenya.

At present these agricultural economies present many weaknesses. Most of them depend on single crop economies which are usually termed "fragile economies." In 1953, for instance, of the 500 million cocoa-bearing trees in Ghana, 10 per cent were found to be infected with swollen shoot disease and millions of trees had to be destroyed. In one year the mainstay of the whole country's economy can be wiped out by adverse weather conditions or the fluctuation of world market prices.

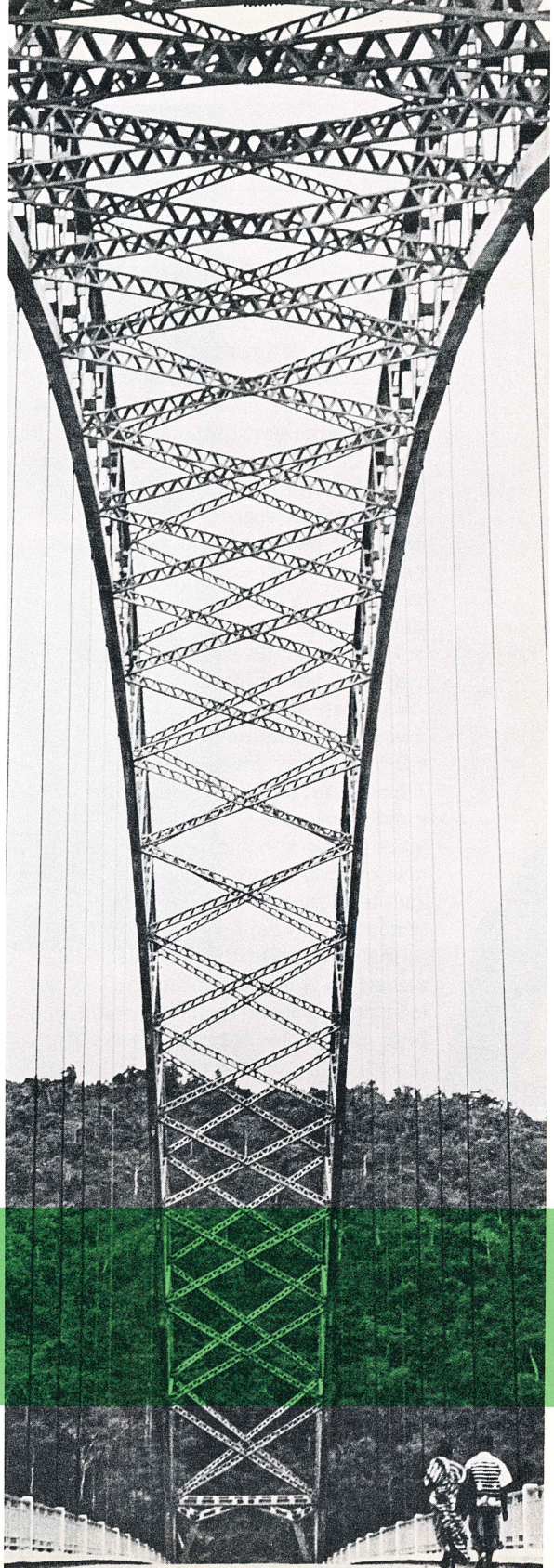
However, large proportions of people in Ghana and Uganda are still engaged only in subsistence agriculture, still tied up in a closed self-sufficient system of traditional family organization and kinship without contributing anything to anyone else. Economists claim there must be more of a break-through here from subsistence farming to a modern technological economy, if the new states are to earn foreign exchange and credit and provide food for increasing numbers of people now being employed in towns and industries.

Even where there has been a change-over to commercial agriculture a low level of production remains. Farms are small and large scale farming has so far proved to be unprofitable under African conditions and may always be so. Per capita productivity and income, therefore, still remain low. Ghana with a population of 6½ million and claiming one of the most prosperous economies in Africa has a per capita income of about $194.00 a year. All her cocoa farms are African owned. Uganda with its 6½ million averages only $57.00 per year; here most of the plantations are still British owned.

Now that these nations are free and struggling to develop, they need capital and skill from the outside to catch up with the rest of the world. Their eco-

"Unless political liberty for which Africans have so long struggled is complemented and bolstered by corresponding economic and social growth, the breath of life which sustains our freedom will flicker out. In our efforts to improve the standard of life of our people and to flesh out the bones of our independence, we count on the assistance and support of others. But this alone will not suffice, and alone would only perpetuate Africa's dependence on others."

(Haile Selassie, Inaugural Address at Addis Ababa, May 1963.)



Copper, mined in Uganda, is purified at the Jinja copper smelter.

Cocoa in Ghana—Cotton and coffee in Uganda —Single crop economies are termed "fragile," dependent as they are on weather conditions, disease or fluctuating world markets.

nomic development is also dependent on world markets to buy their products, and their products must compete with similar commodities from better developed countries. The cost of production is not always lower because unskilled labor often takes longer to produce. Laborers are often only part-time and unskilled, as they must also spend time producing their own food. Millions of Africans cannot work more than four hours a day because they are undernourished or are infected with hookworm or malaria. Countries with single cash crop economies also sell the major proportion of their produce to one or two countries—thus making them virtually economically dependent on certain "market nations" who can exert economic pressures on the newly emerging nation. This is what is meant by Neo-Colonialism and is so strongly opposed by President Nkrumah of Ghana.

Thus the overwhelming problem facing the developing nation remains, that unless agricultural productivity is increased, greater funds will not be available for the very basic needs of food, shelter, clothing, health, education, training, etc. And commercial agriculture itself cannot become more productive unless more funds (capital) are available to spend on scientific research, equipment, fertilizers, tools, agricultural training, etc. Industrializing, setting up factories that goods may be manufactured on the spot, also requires capital but will eventually bring its own return. Ghana's realization of the great Volta River Dam Project is linked up with the dream of the production of its own chocolate. The world's greatest producer of cocoa still depends on other nations to provide it with the finished product.

The economic policies of a country like Ghana may seem very complicated to the average person. Nevertheless, they underly the very structure of daily life and as such are woven like a fine network into the Medical Mission Apostolate.

Bad health is without a doubt the most serious obstacle to a nation's economic and social government. Man becomes caught and involved in the well known vicious circle: poor because he is sick, sick because he is poor. When disease is rampant, production drops, dragging down with it salaries, standard of living, food consumption. As the standard of living rises, more money can be spent on preventive medicine rather than just curative. Workers can increase their knowledge and go on to higher positions more in keeping with their aspirations and dignity.

Curative, preventive and ancillary medical services have been greatly expanded by the governments of Ghana and Uganda in recent years, but the need for trained medical and health personnel is still keenly felt. More clinics and hospitals are also greatly needed in the rural areas, but the twin obstacles of insufficient funds and lack of personnel must first be overcome.

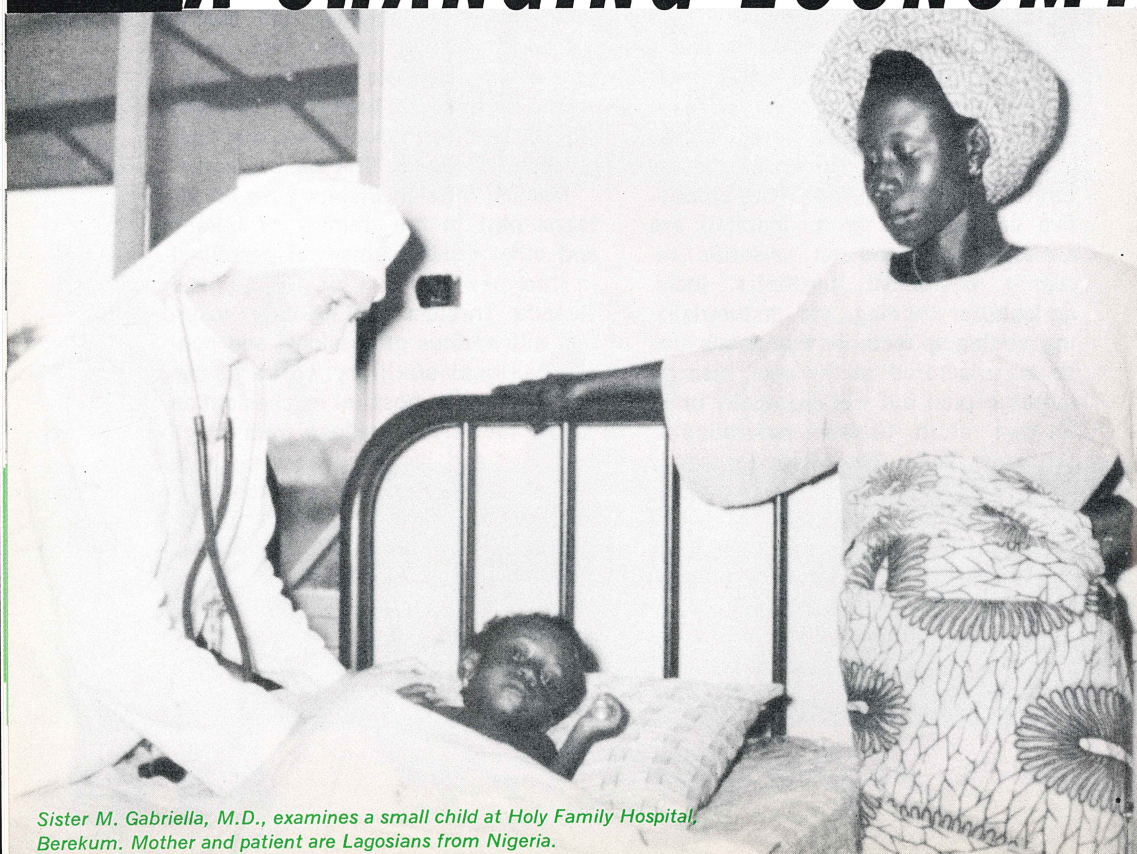
Medical Mission Sisters have an integral part in the training of nurses and other qualified medical personnel in the new nations of Ghana and Uganda. Through staffing their hospitals with various professional and non-professional auxiliary workers, the influence of the hospital reaches out as far as the farthest village from which a worker and his family come. These workers number well over a hundred in each of our large hospitals. Multiply this hundred by six, seven or ten members in a family and one can see how the benefits of a modern Christian hospital radiate like spokes from the hub of a giant wheel.

IMPACT

Of on DISEASE

Sister M. Fernande, M.D.

A CHANGING ECONOMY



Sister M. Gabriella, M.D., examines a small child at Holy Family Hospital, Berekum. Mother and patient are Lagosians from Nigeria.

To evaluate the diseases of a country in relation to its economy is a broad and difficult task, especially in an emerging nation with a rapidly evolving economy—the picture of Ghana today. As a young country develops, disease patterns change. New situations create new problems.

The town of Berekum, 300 miles inland from the coast where our Holy Family Hospital is located, is perhaps less dramatically, though nevertheless quite really, affected by Ghana's efforts at progress. Observations drawn from our hospital files demonstrate very real influences being exerted by the medical mission apostolate and encouraging trends in the attitudes of the people.

"Years ago," Sister M. Camillus will tell you—late 40's, early 50's—"we did not see so many different tribes here in Berekum. We had our own Brongs and Ashantis. Now we see many Ewes and Gas from the coast; Dagartis, Lobis and Moshis from the Northern Territories; and so-called 'French' tribes from the Ivory Coast and Togo side." This intermingling of different tribes moving down to seek their fortunes brings with it cultural variations as well as variations in disease patterns.

The diet of the Northern Territory people, for example, in contrast to that of our own, is quite poor in protein and eking out a living entails hard work for them. This accounts in part for their large hernias and slow wound-healing processes. Parasitic infections are more common and schistosomiasis more frequent among them too.

It is especially heartening to see these out-of-town people, particularly the younger couples, taking advantage of our medical facilities. Very often the wife doesn't understand Twi, our language, at all and the husband, only a little. They usually bring a friend of the family along to act as interpreter. I sometimes wonder, after double or triple translations, whether there is any resemblance to the original.

One little Moshi lady delivered her first baby here. She didn't understand English or Twi but through sign language, the gift of mutual understanding sans parole, and with the help of her husband who refereed from the veranda, things went along unusually well. At one point, Sister wanted her to relax which she indicated by finger-over-lip "ssh, ssh." Our little friend, thinking it was part of the delivery, followed suit with her finger over her lip and "ssh, ssh."

A Lobi man had his eight year old child admitted with severe bronchitis. The lad had an uneventful recovery. Several afternoons later a lorry drove up with the same man and three other children, all of whom were sick with a respiratory infection. "Your medicine is good," he said. "You cured Kwame. See what you can do with these three."

On the whole the people are seeking medical help sooner now than they did even a few years ago. The cases of weeks of illness complicated by native treatment and enemas, although still seen, are a bit rarer. This is true of our people in Berekum and the nearby villages, for example Nsuatre and Jinijini where economic and living standards tend to be more progressive.

It is not infrequent for a mother from these villages to bring her child, active, playful and alert, to the OPD and hear her say, "Kwasi had fever last night. He became very hot so I sponged him down." (This she learned at Holy Family Hospital.)

I always consider it an indication of growing trust on the part of the people that they send their children unac-

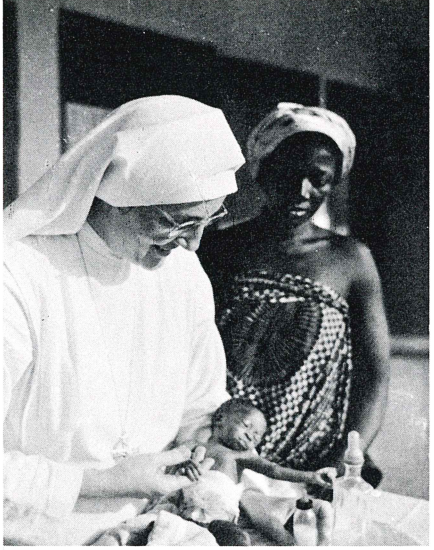
companied to the OPD, knowing that we will give them our best treatment and care.

One thirteen year old Berekum boy was advised admission. As he had come by himself, I asked him to send word to his parents. Anna, the nurse, intervened. "You can admit him, Doctor. I know his father. I will tell him. It will be all right."

At one time—and not so long ago—it was unheard of that a patient for whom nothing more could be done medically would remain in the hospital for his last days. "To die at home" was unquestionably taken for granted. This attitude, however, is beginning to change as the benefits of nursing and spiritual care which our hospital is able to give are being seen and appreciated by the people. They are quick to sense that a person should die in dignity and that this is as it should be.

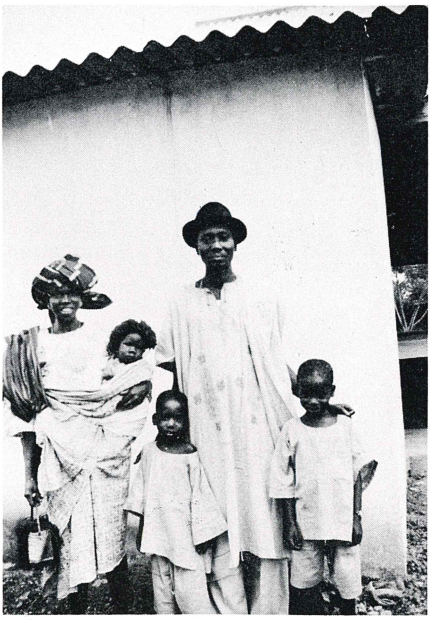
I knew Adwoa Nsiah, a fifty year old matriarch of a well-known family in Kato, a village one mile from Berekum, ever since I came here. She had cancer of the stomach and came fairly regularly to the OPD for medicine. One day I had to explain to her nephew the essentials of her disease and warn him that I did not think she had much longer to live. A few days later she returned with the elders of the family—husband, brothers and older children. Would we consider admitting her to a private room at their request? She died not too long after and the family was most grateful for the services we were able to give her. "You see," they said, "we could not give her this care in our compound. How could we have relieved her pain?"

Recently, the chief's mother was admitted with cardio-vascular disease. It soon became obvious that treatment was ineffectual and we informed the family. No effort was made to take her



"Mother and baby doing very well," is Sister Marianne's report from Holy Family Hospital, Berekum. The baby was premature, fortunate enough to be born in a hospital where expert care saved its life.

A Lagosian family, the "traders" of Ghana, distinguished by their dress and the color, blue, which must appear somewhere in their costume.



home. When she died, they too were sincerely grateful for the care given.

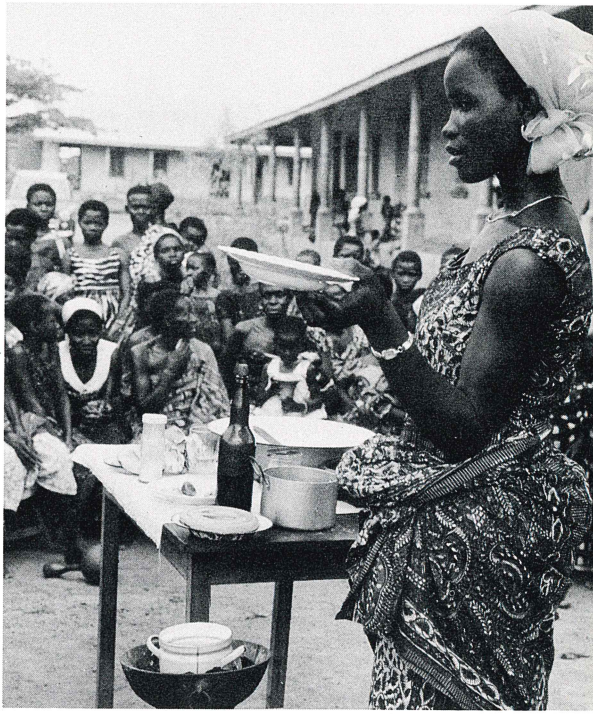
Sometimes, it is the patient who settles the matter. Anthony Amoah's father had decided to take him home. He was dying of anuria and uremia and had only a few days to live. But Anthony adamantly refused to go home. "I'm staying right here." Turning to his brother, he asked, "Who will take care of me at home? Who will give me the injections?" He stayed and very soon went to meet his Maker with that child-like trust and faith so characteristic of our people.

Public roads in Ghana today have improved a good bit and travel via lorries and taxis is becoming more and more common. However, this step forward has created new problems for us medically. It is no longer unusual to admit six or seven patients at a time, all involved in one lorry accident. Last May, a bad accident eight miles from Berekum injured over sixty people. Half of them needed hospitalization. There were many fractures and a total of six deaths. Our staff was tremendous. Our Ghanaian nurses really "rose to the occasion" and gave example of generous, competent nursing care.

One can sense an awakening in the country as a whole and, more keenly, in the medical and paramedical fields, to the essential need for more public health measures. Although still in their organizational infancy and hindered by the ever-present lack of personnel and funds, some palpable measures have been taken. The well established leprosaria and leprosy control units treking to the villages are just one example.

The Kwame Nkrumah trust fund helps to finance societies for the blind, deaf and crippled. This is certainly an indication of progress in a land where

Girls from the nearby Government Training College come to Holy Family Hospital to give talks on proper nutrition.



Empty bottle is exchanged for full one. Mammy thinks it is a good deal. Baby is content, too.

survival of the fittest has been the rule and where the care of invalids has been considered a prerogative of countries with long established medical programs.

Recently, a Red Cross unit was started in the Brong-Ahafo region with offices at Sunyani, twenty miles from here. Discussion has begun on the question of blood donors, hoping to be able to draw them from the students at the nearby Government Training College and from the police force.

The College nutrition department sends some of its girls to Holy Family Hospital on Wednesday, our prenatal clinic day. These girls give talks to the mothers on proper nutrition for themselves and their children. As they are speaking their own language and talking about their own foods, they make an impression. Not infrequently, the patients will sit through the same lecture two or three times.

A dental mobile unit has also been initiated, treking the area. It is interested mainly in preventive treatment among the school children but it is also equipped to do emergency extractions and to provide other dental care as needed.

All of these advantages are very encouraging but little reason to take a complacent attitude. Age-old miseries still exert themselves with an insistence impossible to ignore. Malaria, long conquered in other areas of the world, continues to be one of our major problems. It has no respect for class, education or age. It is always there as a primary disease or as a complicating factor in other disease entities. It is a killer of the young and a devastator of the health of those who survive. A student attacked by malaria is certainly in no mood to study and a teacher with a similar attack is not able to teach. Current anti-malarial drugs are known and many people, especially the educated, take camoquin or chloroquin when they feel the fever coming on, much as people take aspirin for headaches in other parts of the world.

There are still too many preventable deaths which could be averted by a greater number of medical and public health facilities. Why should a father and mother have to watch their ten year old son die of rabies?

"Go to the hospital in Berekum," a teacher in Sampa (70 miles away) told the father of one of his pupils. And the man came, his desperately ill daughter in his arms, the strain of the journey in his eyes. Here was hope. Perhaps "they" could do something. But it was too late. The girl died within one-half hour of her arrival. And yet there was hope. "Papa, she has gone to God's house. She has gone to live with God." "Ampa . . . it is true," he said. "Nyame wo ha"—"God is here."

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NAME_____

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Your name?

Your village?

Your work?

By Sister M. Philip

In Uganda's Hafu Valley, a Mr. Wayland, in 1919, found tools which are known to be the oldest in the world. These tools were made from pebbles, split and trimmed. They are thought to have been used for skinning game, scraping and shaping hides, cutting meat into chunks—the occupations of those first inhabitants of the Nile Valley.

The present descendants of those ancient tribes are still engaged in the day by day struggle of providing for their families. The need for earning a livelihood remains the same; only the manner has changed, has evolved to include a variety of occupations. We rub shoulders daily with these people who call Uganda home. They are our patients. Every aspect of their lives is a source of interest and concern. "Your name? . . . your village? . . . your work?" These are questions of moment at Holy Family Hospital, Fort Portal, Uganda.

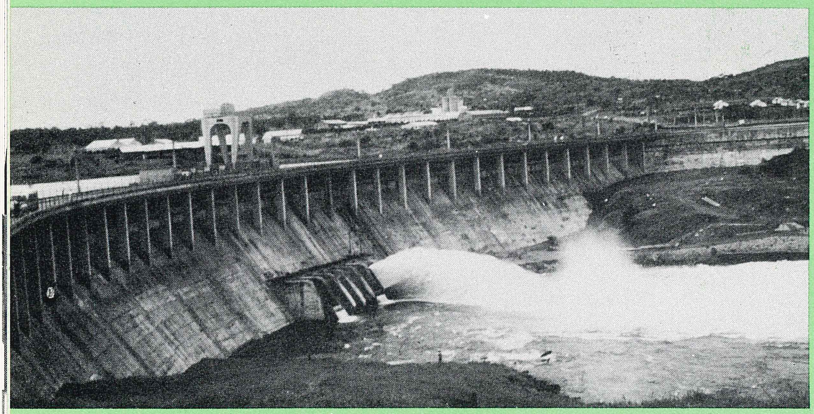
The little kingdom of Toro, where Holy Family Hospital serves its people from literally one end to the other, is situated in the western sector of Uganda. The people come to the hospital from near and far. Also, on a rotation basis, the hospital goes to them. Twice weekly, our trusty Beford van with doctor, nurse-midwife, pharmacy assistant and secretary takes a safari, 100 miles to the south and 100 miles down around the mountains to villages along the Congo border. These trips give us a good opportunity to meet the people in their own environment. What do they do for a living? Come along with us and see.

Your name? Your work? Routine questions at Holy Family Hospital, Fort Portal.

The chain of the famous Mountains of the Moon runs northeast to southwest through Toro. On the top and sides of these mountains dwell the Batoro, Bakonjo and Baamba tribes. These people are primarily tillers of the soil, as the foothills of the mountains provide good farming land with cash crops of tea and coffee. On the Congo side of the mountains, the temperature rises dramatically. Here, too, coffee is grown and cocoa is being introduced as another cash crop. Citrus fruits are also grown, but mainly for consumption within the area.

To the south and up into the mountains, the large Bakonjo population concentrates on coffee and cotton. Large cotton farms dot the valley. The families live on their own little garden farms and go down into the valleys at planting and harvesting time. These people have a good, steady income, so that diseases such as kwashiorkor and malnutrition are not found to any great extent. However, education with regard to a proper diet of proteins and vitamins is still a primary aim. As the climate here is cold and damp, T.B. and upper respiratory diseases are prevalent.

Dinner time in Uganda. A mother feeds her son outside their village home.



Jinja Dam provides hydro-electric power, full of potential for the growth of an industrial economy in Uganda.

In the foothills of this region are found rich deposits of copper and cobalt, the life-lines of the Kilembe mines. The frozen foods industry has recently staked a claim on the shores of Lake George and the waters are daily panned for their white gold—the ngege fish—which tastes like meat.

The nearby Queen Elizabeth National Park is a beautiful natural habitat for elephants, wart hogs, deer, cob, lions, water buffalo, hippo, etc., and a place of employment for many who live in the surrounding area. It provides occupations for rangers, hotel workers and sailors who navigate the waters of the lake. The most dangerous of these occupations is that of the ranger. A young man once arrived at our door with this note attached: "This ranger had an argu-

Coffee picking in Uganda.

Industry moves in. Prime Minister Milton Obote making a tour of a teacup factory in Kampala, Uganda.

ment with an elephant. Kindly give him the treatment he needs." The X-rays showed a badly damaged shoulder.

Tea plantations have long been a part of Uganda. The climate is ideal for growing tea and the neat, well-ordered estates with their trim rows of flat bushes are a sight to see. Here, as in the parks, at the fisheries, in the mining camps, housing is provided for the workers.

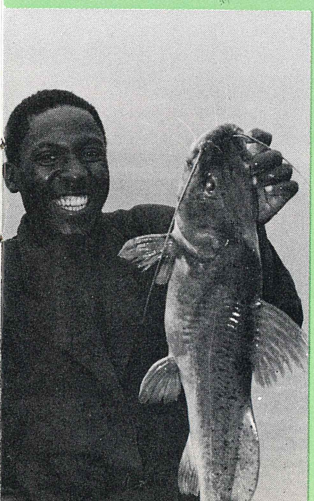
Once back at Holy Family Hospital, Fort Portal, we see a different picture. In and around the town itself, there is a great variety of occupations, those occupations provided by any town—clerical workers, shopkeepers, civil servants, business men, teachers, etc. The people employed at these tasks receive a level of income sufficient to overcome the environmental conditions which usually give rise to poor health. They are able to provide good food, comfortable homes and an opportunity for education for their families.

The outlying districts surrounding the village present a different picture. The inhabitants of these areas are farmers

There is no mistaking the fact that the whol of Africa is awake to the need for a diversified economy and speedier industrialization. Copper is purified at the Jinja Copper Smelter in Uganda.

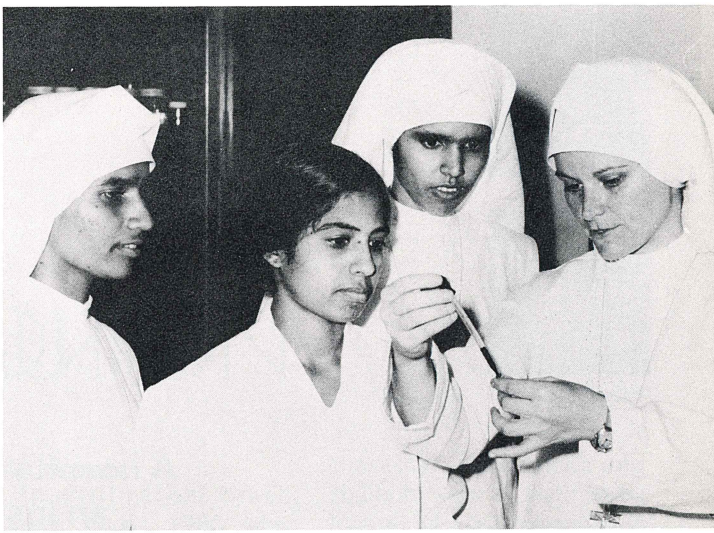
like their distant mountain neighbors, but their farms do not begin to compare with those farther north and south. They are mainly bitooke (banana) plantations, but the yield barely suffices to meet the family needs. However, the agricultural department has inaugurated several research and development programs, so there is hope for improvement in the future.

This, then, is a brief sketch of the occupations which our patients call their own, so important to know when health is a daily concern. "And what do you do for a living?" The question remains the same, but slowly, very slowly, the answer is changing.



He has reason to smile, with plenty of fresh fish in his diet and the fishing industry expanding.

Commitment
is a
Word. . . .



. . . . *that means courage,*
a word that has grappled with alternatives
and made a choice.

Its hand is on the plow. It knows not to turn back. Commitment decides what's inside a man, how deep his knowledge of his own indebtedness. The more he perceives, the more total his response.

Even all of life is not too much for some.

A man can be committed to a task—
and huge monuments come forth from his hand.

A man can be committed to an ideal—
his life blood for equality, freedom, liberty—
and a new order is born.

A man can be committed to a people—
to the people of the family of God—
and the Church finds herself at home across the face of the earth.

This man is a missionary.

NO SMALL

A hospital in Uganda is not only an institution for healing. A leprosarium in Ghana is not only a settlement for the diseased. Centers of healing, while aimed primarily at caring for the sick, do at the same time offer more than the obvious health service to an area. They give opportunities for steady employment to the local people, no small contribution, especially in young emerging countries struggling to improve their economy. In the following reports, Sister M. Paula gives us a glimpse of the work situation at Holy Family Hospital, Berekum, Ghana; Sister M. Darrah takes us behind the scenes at a new, young hospital in Fort Portal, Uganda; and Sister M. John describes a leprosarium arrangement where work is therapy.

Sr. M. Paula

Sr. M. Darrah

Sr. M. John

CONTRIBUTION

BEREKUM

The non-professional employees at Holy Family Hospital, Berekum, may be divided into two classifications—the laborers and the artisans. The artisans make up the group of workers who have pursued and mastered a trade through an apprenticeship. These workers include electricians, cooks, carpenters, masons, tailors and painters. The larger number of non-professional employees making up our staff include gatemen, garden and grass maintenance workers, laundrymen, ward and house cleaners, night watchmen and cook's assistants.

Who are the people who come to Holy Family Hospital seeking employment? As can be seen, the butcher, the baker and the fufu-ball makers, plus a multitude of other people looking for just any kind of work.

Up until recent times, namely, about 1960 when Ghana sat up with a great big yawn and decided that the era of industrialization had arrived, the only reservoir of labor in the country was the subsistence sector, where people raised crops for their own consumption. The production of food in Ghana, other than cocoa, is estimated to employ about one-half of the adult population. Cocoa production employs one-sixth of the population. So the applicants for these non-professional posts generally are not accustomed to regulated hours of work and exacting work-production, since on their own farms punching a clock is not in vogue. Great patience needs to be exercised in this area.

Generally, the only requirements for the category of laborers are those of good character, willingness and ability to work as testified by letters of recommendation and by appraisal during interview. Frequently one finds that these letters of recommendation with flowery, glowing terms are written by the applicant's uncle or brother. A person who has schooling might apply for this type of work only if he thought he would later get a better post. Since the women usually work the farms or sell in the markets, it is very seldom that they apply for housework. So all of the cleaning posts are open to male workers both in the house as well as on the wards.

The Ghanaians are very quick to learn. In the case of the artisans, there generally is no problem with the actual work. There may be some difficulty for the carpenter if the design for the furniture you want is something new

to him. But he is very good at copying, and all that is necessary is to give the dimensions and a picture of what you want. With the laborer it is a bit different. Chances are he has never worked for anybody other than his father or uncle before and the idea of a job, an employer and work production is comparatively new to him. There is always a period of adjustment, as there is everywhere, but once he knows what is expected of him, he assumes the responsibility readily. Of course, the necessity to check on his continued good work is always there, as it would be anywhere. He must learn that in working for an employer he cannot waste time as he could have done on his farm.

Our employees, their wives and children receive free medical treatment and hospitalization. After working with us for five years, they are eligible for a gratuity of three months pay should they leave the job. They have the various benefits of annual leaves, national and religious holidays as well as casual leave. They appreciate the fact that we give them religious holidays, something that other institutions do not do. The employees are being encouraged to start savings accounts so that in the future their children may have the opportunity to go to school. This is one area which can really be developed, and plans are being worked out so that all the employees will learn how to save their money. With the clan system of expecting help from fortunate members who are making a good salary, it is very difficult for the individual concerned to put enough by for that rainy day.

The women of Ghana are good business women. They set up shop at the local market to trade their products.

One of the reasons for wanting to work at Holy Family Hospital, aside from the benefits, is the fact that there is an opportunity to learn a little bit of English. This is considered an asset. Frequently, too, when there is one person working at Holy Family Hospital from a nearby village, he tries to get work for many of his neighbors, since the pay is steady and the wages are just. Farm workers cannot always count on a regular wage. It may be that sometimes there is not enough money available to pay the workers and so they either receive something in kind or they just have to wait until the cocoa money is in.

Most of the employees at Holy Family Hospital come from Berekum state and the surrounding areas. The people of Berekum and the villages really appreciate the fact that besides having the commodity of a good functioning general hospital for their sick, there is always the opportunity for the people from their village and town of receiving work at the hospital.

FORT PORTAL

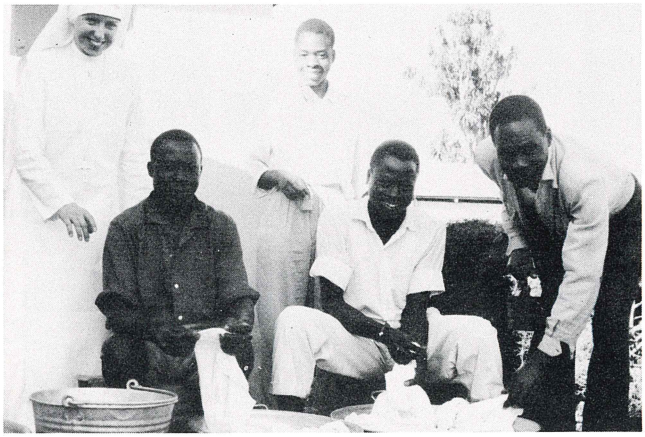
Our non-professional employees include workers in administration, laundry, transport, kitchen, housekeeping and grounds. Very often the non-professional employees receive their training on the job. For example, in the out-patient and in-patient admission offices the worker generally comes to us right out of school. He is trained first to routine registration, filing and later to record keeping, switchboard, monthly reports and ledgers.

In housekeeping, the worker is trained to scrubbing floors, dusting, brushing down ceiling and walls, washing windows, etc. (These may seem like works that would

require no training, but these people come from very simple huts.) Once an employee asked me, "Sister, what is the purpose of this dusting? Do you get sick if you don't dust?"

In transport, the driver is expected to have the van clean and ready for all safaris —four days each week. Car maintenance must be taken care of on off-safari days. A skilled driver is needed for safaris. Some of the roads are only narrow, uneven mud paths, and here it rains a lot.

Whatever the work of the non-professional employee, we look for a sense of responsibility. Does he come on time in rainy season? Does he do a full day's work, etc.? We also watch to see whether the employee is happy in his job. Happy workers work well and are an asset to the esprit de corps of the hospital. Increments in salary are given at intervals and also on merit.



Four reasons for the joyful spirit among the workers at Holy Family Hospital.

All employees receive free medical care for themselves and their immediate families. The employees get paid vacations after one year of service. We have only been at Holy Family one year so this benefit is just beginning to go into effect.

In this short time, too, the family spirit and pride one hopes for among the employees is beginning to be formed. We pick it up in small ways. For example, the medical safaris often call for irregular hours. The schedule is never questioned. How many times our workers have shown great willingness to fill in on short notice. On one occasion, a laundry worker said, "But, Sister, who will finish this up if I am off this afternoon?" A kitchen worker (who writes only in Rutoro) always puts "HOLY FAMILY HOSPITAL" at the top of the page when he writes his letter home.

So gradually the non-professional employees become aware of their real contribution and increase their ability to assume responsibility at Holy Family Hospital, Uganda.

Some women patients of Kokofu Leprosarium proudly exhibit the fruits of their labor to Sister M. Francis.

KOKOFU

Most of the actual work around the leprosarium is done by the patients themselves. Young men trained by the ward Sister as ward help-

The patients learning to make seedling baskets for the Agricultural Department.

ers; the teacher, qualified according to the standards of the country, tailors and apprentice tailors, weavers, kitchen and laundry personnel; farm laborers and those who make cocoa seedling baskets for the Agriculture Department—all who are able, want work and are given work according to their abilities and capabilities. Because work is part of the therapy and a good deal of it comes under rehabilitation, these people are not paid a salary as such but get a monthly bonus according to the type and the amount of work done.

Among so many (about 130), backgrounds vary, as does a sense of responsibility, thoroughness, efficiency and ability in general. However, even those from the far north where all is still very primitive, eventually find their place and prove themselves to be very efficient and responsible. These, after they are discharged, can easily find work and have no difficulty keeping their jobs.

Those who show a sense of responsibility are given positions where this quality is most necessary. These need very little supervision. Farm laborers, however, need constant supervision if any work is to be done. However, the work is secondary to their sickness, so not too much is expected and judgements are reserved. It has happened too often that one sees an apparently healthy looking giant listlessly hacking away at a few weeds in a path every day for a year or more. Then, suddenly, he is a different man with a burst of energy and new light in his eyes. He wants different work and is soon one of our best and most reliable workers. When this happens, we know he is "over the hump" and on the road to recovery. In good time, for there just simply is no rush in Kokofu, he is discharged and adjusts very quickly to a normal life and livelihood.

And so they go, one by one, a joy and comfort to the hearts of those who stay to see and receive others who come to fill their places, knowing that Our Lord, in sending them here, wants them to have a new life and wants us to help Him give it to them.

This patient has become a skillful weaver. Work is part of the therapy at Kokofu Leprosarium.

Mama Ata —BUSINESS WOMAN

By Sister M. Daniel

Mama Ata stood at the office door with her wrinkled face unlit by her usual broad smile. We knew why she had come. Sister M. Francis, M.D., had asked us to tell Mama Ata that she was discharged from the leprosarium. Her leprosy smears had long been negative, and the ulcers for which she was admitted for treatment were all healed. To most of the patients at Kokofu Leprosarium, this would have been good news, but not to Mama Ata.

Mama belongs to the "pre-sulfone era." She has no fingers, but is very adept at managing with the stumps of her hands. Her toes, too, have disappeared, but not her smile—usually. The new sulphone drugs if taken soon enough can prevent deformities such as Mama Ata's, but she happened to contract leprosy a few years too soon. Her disease is arrested, but the sulfones arrived too late to prevent the loss of her fingers and toes.

Mama Ata was one of the pioneers in Kokofu—one of the first patients to be admitted. Quickly she made herself at home in the little house provided by the Settlement. Mama planted her "farm" in the Settlement bush and housed her chickens in her back yard. As she was very sociable, there were always visitors on visiting days. Sometimes even the Kokofuhene (Chief) came to pay her a visit, arriving in his sleek black car, dressed in his ceremonial ntemma (cloth) and escorted by his umbrella carriers and members of the royal family.

Mama seemed to do a thriving business marketing her eggs, chickens and farm produce among the other patients as well as among her friends. She was truly grateful for admission to the Settlement and expressed her thanks by frequent "dashes" of eggs to the Sisters. We had a suspicion that Mama somehow believed she would not have to leave the Settlement as the other patients had to do when their treatment was completed. Today, we knew it was

true as we listened to Mama Ata plead her cause.

"I cannot go until my farm has been harvested," she began.

This was not a valid excuse because the land was Settlement land, and farming was part of the occupational therapy. Although patients were allowed to do as they wished with the harvest from their individual plots, still it was Settlement produce grown from Settlement seed, and the patients were there for treatment—not for profit.

Finally, after much palaver, the real story came out.

"My home is in the Chief's Palace, but one who has leprosy cannot live there. The Chief built me a house of my own before I came to the Settlement, but now it has fallen apart in the rains. The Chief will build me another house, but it will take a few months."

We told Mama Ata there was no reason why she had to live alone now. Her leprosy was arrested. She could move in with someone else at the Palace. Mama Ata only raised the stumps of her hands and reiterated, "But no one who has ever had this disease may live in the royal palace. It does not matter who says I am all right. Everyone can see my hands—that I was once a leprosy patient. I must live apart. This is our custom, and I must follow it."

At the time, we were not sure whether Mama felt bound by the particular tribal custom she described, or whether she was taking her stand as the venerable elder tribeswoman she was, to prescribe the proper procedure in her own case. In Ashanti the older women of the royal family are the power behind the throne. They are the staunch upholders of tradition, and no Chief and his Elders would initiate any action without consulting them. At any rate, Mama Ata made it very clear that she could not return with her relative, the Chief of Kokofu, to his palace because of her present deformity. She must have her own house. Neither could the Settlement deviate from its purpose of treating leprosy patients to become a custodial institution even in this case. Firmly, we stood our ground; Mama must leave the Settlement.

But Mama was a very enterprising woman. She made one last stand.

"I shall return from time to time to pick some of the produce I have planted."

We impressed on Mama Ata that this was unfair to other patients who had recovered. No such privileges were given to them. Neither could she expect such treatment. Mama gave no answer, just went off smiling, probably reflecting on how little these Bruni (white) people know about the land customs in Ashanti. It is true, the people believe the land really belongs to their ancestors and the Chief holds it, only in trust. He must take care not to offend the ancestors in using it. These facts might well have been the framework of Mama Ata's thoughts as she left the office and prepared to leave the Settlement.

The name of Mama Ata had almost been forgotten at the leprosarium until one day several months later. During the usual noon siesta, we were unexpectedly called for some business at the admission office. Suddenly, someone came strolling down the path—Mama Ata. On her head she carried a tray piled high with plantain and cassava picked, we felt sure, from her former plot of land. The look on her face was plain to read—we could send her away from the leprosarium but the land belonged to her ancestors and they would surely want her to have the produce. We could only smile and agree—Yes, surely, Mama Ata.

NEWS FROM OUR HOUSES

UGANDA

Beginnings

On the feast of the Holy Family, January 12, Holy Family Hospital, Fort Portal, opened a school of nursing. It is the first training school located in the western area of Uganda. The next closest school of nursing is in Kampala, 300 miles away. For our girls from the western part of the country to go there would be like going to a whole new world. Few, if any, would dare. This is one reason why our new school means so much in this area.

Sister M. deMontfort
Holy Family Hospital, Fort Portal

PAKISTAN

Emergencies

There are always emergencies here . . . some are really so, some exist only in the mind of the patient, and some are concocted by relatives to by-pass the nuisance of registering at the desk. The other day a peaceful dispensary was disrupted by the cry: "Emergency" with great to-do. The relatives said it was "skin disease." Rule No. 1—get the relatives out of the way. Rule No. 2—examine the patient. Her skin was as clear as an ad for Camay. Then the doctor asked the patient—"What's the trouble?" She said, "Ten years married—no children." That is an emergency!

The aim of every married woman in Bengal is to bear a son. Every day I see a procession of woeful creatures with a list of physical complaints a mile long. When they have finished their recital, I ask one question, "How many sons do you have?" If the answer is "None", I know immediately what the real problem is.

The women are so keen to bear a son that they diagnose practically any abdominal swelling as a pregnancy. We had a 16 year old girl in recently with such a painfully distended abdomen.

Before surgery we drained out nine quarts of clear fluid. At operation, eight and a half pounds of solid tumor were removed. We figured that this "baby" weighed a total of 27 pounds. As Soukat Ali herself weighed only about twice this, you can imagine what a burden the tumor was, borne uncomplainingly in high hopes that she would be lucky enough to have a son.

Sister M. Angela
Holy Family Hospital, Dacca, East Pakistan

INDIA

What Is Important

Here I am making hundreds of discoveries. First, my trip to India was quick and from there on, I entered a new world. It is true that one adapts very quickly. Already, I am not in the least surprised to find a patient's companion on the floor next to her bed or outside the delivery room, patients with their clothes on in bed receiving their food from a sati (relative), etc. However, these things are not the important ones. What is important, is that there are people here in real need, so helpless, so sick. Indeed, I can say I have never seen the poor so poor, the sick so sick, and your heart just goes out to them.

A few hours ago, I had to refer a patient with tetanus to the Infectious Disease Hospital so that she could receive the adequate dose of tetanus anti-toxin. The mother went to the floor kissing my feet and the patient lifted up her hands in supplication—oh! how much it hurts. The whole story is really a pattern. The first child, delivered at home, died of tetanus. The second delivered at Holy Family Hospital is still alive. The third was delivered at home ten days ago, the cord cut with a dirty razor blade. The child died with that horrible smile on his face, "risus sardonicus" it is called in medical literature, and mothers here know well the horror of this look. Now she, the mother, cannot open her mouth with the same disease.

Sister M. Paul, M.D.
Holy Family Hospital, Patna

Sister M. Victoria and Sister M. Gertrude with a graduate and her family. The mother is wearing the Palestinian country dress.

JORDAN

"Firsts"

Doctor Nabulsi, Assistant Minister of Health, presented diplomas to our first five students, graduates of our Practical Nurses Training Scheme here in Jordan.

From the very beginning it was planned to start a training school for nurses in connection with the hospital but, as a full course was not possible, a year's course for practical bedside nursing was decided upon. We made inquiries whether other such courses were being given in Jordan and discovered that, although the Government and the Jordan Nurses Association were planning such a course, they were not ready as yet to implement it. Very happily we worked with the Jordan Nurses Association and adopted their syllabus in our courses. Sister M. Gertrude is in charge of the school.

On Graduation Day, there was much excitement with the Junior Students rushing around trying to help. The families of the graduates were so nice to see—some of them in Bedouin dress, and all so proud of their girls.

Sister M. Alban
Holy Family Hospital, Amman, Jordan

INDIA

Religious of India

This weekend we had the first meeting of the Bihar Patna branch of the Conference on Religious of India. There must have been at least 100 local Sisters present at each of the meetings. The general topic was spirituality and the apostolate—four talks, two on education, one on medicine and one on social work.

One of the points brought up in the medical session was whether religious are good hospital patients. I was glad to be able to answer that, not only are they good ones but most often, exemplary. I could honestly say that I had never been disedified by anyone but ordinarily, most impressed and helped spiritually by the way they accepted their sufferings, etc. In my eight years in India, I have found that most of them used their hospital stay in an apostolic way. It speaks well for all these religious, since one's defenses are down during illness and it is not so easy then.

Sister M. Frederic, M.D.
Holy Family Hospital, Patna

EAST PAKISTAN

Population Density

Last weekend I accompanied Sister Rachel to a wedding. The son of our nurses' housemother was marrying a girl from a nearby village. The marriage, as is traditional, had been arranged by the family but the boy and girl, in this case, had already met. It was on this trip that the cold statistics of population density hit me for the first time. After disembarking from our river boat, we travelled on horseback for three or four miles across the open fields to the village. Most of the land lay empty, awaiting the next rice planting. Every few acres there would be a clump of trees and nestled among them, a bamboo hut or two, some chickens, a few cows and always, many children running about. This was real "country" and I felt right at home except for one thing —so many people. Everywhere I looked in any direction I could count 10 to 20 people, working or mostly just chatting in the fields. This is what it means when you read there are 940 people per square mile in East Pakistan.

Sister M. Austin, M.D.
Holy Family Hospital, Dacca

INDIA

Student Nurses Win Prize

Holy Family Hospital Training School, Patna, was represented at the recent Convention of the Student Nurse Association of India in Chandigarh, the capital of the Punjab. Our students presented a seminar on Disaster Nursing, took part in the Nutrition Drama contest, and won first prize in the Elocution contest. In between they had an opportunity to view the new, completely planned, modern city of Chandigarh, designed by the French architect, M. Le

MAGNIFICAT

Sr. M. Madeleine Sophie Du Vally, who celebrated her Silver Jubilee in the Society last August, died on February 11 at the Provincial House here after several months of illness. She was 63 years old.

Sr. Madeleine Sophie was born in Providence, R.I., and entered the Society in 1936 after working for some years on the staff of the Academy of the Sacred Heart, Elmhurst, R.I.

In her twenty-five years of service Sr. Madeleine Sophie has contributed richly to the Society. She has held, at various times, the position of Postulant Mistress, a member of the General Council, Superior in Washington, D.C. and was on the staff in Atlanta, Ga.

Her wonderful human kindness, deep interest in the work and development of the Society and personal concern for each individual Sister will be remembered by all. The genuine acceptance of her sufferings these past months is a rich legacy she leaves to the Society. She died quietly—a simple "returning home" for one who had been going steadily in that direction all her life. May she now enjoy eternal rest.

Corbusier. As the train trip to the Punjab takes over twenty-four hours, they also saw a good part of northern India.

Soon after the students' return, we had the combined celebration of the fifth anniversary of the hospital and the blessing of the new students' nursing home. This was followed by a most enjoyable variety show. The people are very graceful and just full of rhythm, so their dancing is beautiful to watch. I think they enjoyed their extra special khana (food) out on the lawn more than anything else, including the movie in the evening.

Sister M. Esther
Holy Family Hospital, Patna

BOARD CERTIFIED

Congratulations go to Sister M. Austin Jung, M.D., who has successfully completed surgical board examinations which qualify her as a Diplomate of the American Board of Surgery. She is one of the few Sister doctors to reach this distinction.

Sister M. Austin graduated from the University of Cincinnati and the University of Florida before entering the Society. She did her medical studies at Woman's Medical College in Philadelphia. After a one year internship at Philadelphia General Hospital, she took a four year surgical residency at Misericordia Hospital, also in Philadelphia.

At the end of February, Sister Austin left for Holy Family Hospital, Karachi, West Pakistan, where she will have many opportunities to use her surgical skill.

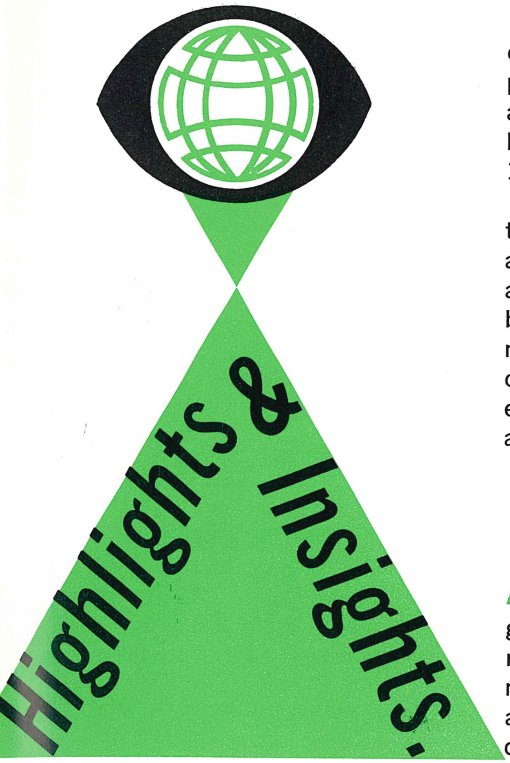
Congratulations to Sister M. Austin Jung, M.D., now a Diplomate of the American Board of Surgery.

YOUR WILL

Your will can help the Medical Mission Sisters bring Christlike charity through their medical work to areas of greatest need around the world. The following approved form of bequest may be used:

"I hereby give (devise) and bequeath to the Society of Catholic Medical Missionaries (also known as the Medical Mission Sisters), an institution incorporated under the laws of the State of Maryland, and its successors forever the sum of $_____ for its purposes,"

If you have already made your will, it is not necessary to make a new one. It is sufficient that a codicil be added, using the above.



In Palestine today there are still 1,200,000 Arab refugees, according to a recent issue of World Health Magazine, which devoted its entire issue to the problem.

When the United Nations sanctioned the creation of the State of Israel in 1948, it did not intend that the Arab population of the territory given to the Jews should be expropriated, expelled or forced to flee. But this is what actually happened. Nearly a million Arabs lost their land and homes and became penniless refugees to make way for Jewish refugees. Today, sixteen years later, nothing has been done to enforce the UN imposed boundaries that would have divided Palestine almost equally between Jew and Arab or to answer the desire of the Palestinian Arabs for repatriation to their former homes or compensate them for the loss of their property. Their homes are across the armistice lines in Israel, on land that had been Arab property for more than 1300 years.

Health problems among the refugees, though less acute than sixteen years ago, are still a matter of urgency and are likely to remain so for years to come because of overcrowding, refuse, vermin, climatic conditions and other causes. Half of the refugees are under eighteen years of age. 40,000 children are born every year among them.

WORLD HEALTH, November, 1963

A communique from the U. S. Public Health Authorities gives us the good news that a U.S. Navy team of research specialists believes it has made a contribution toward advancing and simplifying the treatment of the dreaded Asiatic cholera.

Twelve members of the U.S. Naval Medical Research Unit Two returned to their headquarters at Taipei, Taiwan, in mid-December after a month at Manila's San Lazaro Hospital—completing their fifth mission to the Philippines. Members of the unit first arrived in Manila in the fall of 1961 to set up cholera demonstration teams to assist local medical authorities in stemming an epidemic of the disease.

The researchers, on this last visit, have been heartened repeatedly by a rapid response of cholera patients to an oral treatment which includes a heavy additive of glucose. The NAMRU-TWO team's studies indicate that a salt solution with fairly large amounts of sugar can correct a victim's failure to absorb salt and water.

Cholera which takes three to five days to run its course exacts great losses in body fluids and chemical sub-

stances from its victims. Unless these fluids are quickly replaced, the patient usually dies.

Heretofore, intravenous treatment, with its attendant complexities in administration, has been the principal means of overcoming the cholera attack. Although initially developed by NAMRU-TWO, the intravenous method has a major drawback, the article explained. Cholera victims living in areas far removed from modern hospitals or clinical facilities often die before reaching a medical center. The NAMRU-TWO research objective has been to further devise an oral treatment which will protect the cholera patient until he reaches a treatment station. They hope in the near future to perfect this much sought after oral treatment.

No man of good will can accept the fact that two-thirds of the world—two million out of every three million men—do not attain the level of normal human development that technology places at the disposition of privileged peoples. Civilization is not worthy of its name if it resigns itself to this collective social sin.

Leon Joseph Cardinal Suenens of Malines-Brussels

What sort of Christian, then, does the present situation call for? Not one who is fear-ridden and insecure, inhibited and ossified, prim and plaintive, fanatical and filled with resentment, but a Christian who is courageous and self-reliant, big in ideas and in heart, dynamic and vital, open and joyful. All this is given by Christian freedom: generosity, tolerance, balance, serenity, naturalness, humor, individuality, strength, self-reliance, courage to think and to decide, hope and be joyful.

Hans Kung, "The Church and Freedom," COMMONWEAL, June 21, 1963

War, hunger, the population explosion, the needs of under-developed nations, the dialogue with the atheistic world—these are the questions which are constantly raised (at Vatican II). But cutting across all of these is an idea which may well be the dominant idea of the Council, the key to everything else—concern for the world of the poor. The realization of this concern has a prerequisite: restoration in the Church of Christ's evangelical spirit.

CROSS CURRENTS, Vatican II—Report on the First Session, Fall, 1963

+ R.I.P.

Please pray for our deceased benefactors

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With head held high
against the eastern rim of sky,
EZECHIEL'S GATE stood
barred

to every transitory thing.
It dropped its guard but seldom:
gave entrance to the King.

MARY the dawn
stood on the very brink of night
when Morning came.
Light

broke upon her softly
as Christ the Key encountered virgin latch.
Life lay in wait
until the Sun passed through its eastern gate.
Then joy: then song:
time had been long, been lonely.
Now we know every day as Easter only.

Sr. Miriam Therese S.C.M.M.

felt certain/ sure

Dear Friend,

I have been

to let you know the problem

new Holy Family Hospital - a/new/thing??

because the patients are just too many for the space.

It's no easy/thing small to build a hospital in the AMERICAN

BUSH. It requires beds and books and operating tables and/

Dear Friend,

This is my second attempt in two hours (and several paragrapshs)

tell you for the page

about all the money we need to help us build a new hospital?

hospital in Techiman, Ghana. What a challenge! What a task that

will be. To build in the bush... 300 miles inland, we are.

means we have to provide operating

bandages and linens boxes and operating tables and

JUST EVERY chairs and stretchers and - oh

ter quit now and let you

help us. Each

figure out ren even send us penni

even being in to take the first st

Dear Sisters — It is so difficult to express a need in a convincing way. But never mind. I understand how much you need a new hospital in Techiman, Ghana. Here is my $ _____

NAME _____

STREET _____

CITY _____ STATE _____

MEDICAL MISSION SISTERS
Philadelphia 11, Pa.